

MONTHLY REPORT ON FOSTER CARE UNDER THE FAMILY DIVISION OF THE CIRCUIT COURT

Michigan Department of Human Services

County
Reporting Period (Month & Year)

NOTE: See non-discrimination & PA 431 information on Page 3.

SECTION A: Children provided care, total days care provided under the jurisdiction of the Family Division of the Circuit Court, and expenditures by order of the family court judge of probate from the **Child Care Fund**.

Line (1)	Type of Care (2)	Number of Children (3)	Days Care Provided (4)	Gross Expenditures (5)	Adjustments ^{1/} (6)	Adjusted Reimbursable Expenditures (7)
1.	III. FAMILY FOSTER CARE					
2.	A. Court Supervised					
3.	1. Family Foster Care payments			\$ _____	\$ _____	\$ _____
4.	2. Other (non-scheduled) payments	xxx	xxx	_____	_____	_____
5.	B. Private Agency					
6.	1. Family Foster Care payments			_____	_____	_____
7.	2. Other (non-scheduled) payments	xxx	xxx	_____	_____	_____
8.	TOTAL FAMIY FOSTER CARE (Sum of lines 3 & 6 for col. 3 & 4 and sum of lines 3, 4, 6 and 7 for col. 5, 6 & 7)	_____	_____	_____	_____	_____
9.	II. INSTITUTIONAL CARE					
10.	A. Court Operated					
11.	1. Detention	_____	_____	_____	_____	_____
12.	2. Group Care Facility	_____	_____	_____	_____	_____
13.	3. Shelter Care Facility	_____	_____	_____	_____	_____
14.	4. Other (Specify)	_____	_____	_____	_____	_____
15.	B. Another County's Institution (Court or DSS)					
16.	1. Institutional Care payments			_____	_____	_____
17.	2. Other (non-scheduled) payments	xxx	xxx	_____	_____	_____
18.	C. Private Institution					
19.	1. Institutional Care payments			_____	_____	_____
20.	2. Other (non-scheduled) payments	xxx	xxx	_____	_____	_____
21.	TOTAL INSTITUTIONAL CARE (Sum of lines 11-14, 16 and 19 for col. 3 & 4 and sum of lines 11-14, 16, 17, 19 and 20 for col. 5, 6 & 7)	_____	_____	_____	_____	_____
22.	III. TOTAL IN-HOME CARE (Total from Column 4, line 8 of the IHC Addendum DHS-2396-A)	_____	xxx	_____	_____	_____

^{1/} Includes debit and credit correction transfers (Journal entry corrections of over or under reported expenditures or revenue).

Line (1)	Type of Care (2)	Number of Children (3)	Days Care Provided (4)	Gross Expenditures (5)	Adjustments ^{1/} (6)	Adjusted Reimbursable Expenditures (7)
23.	IV. INDEPENDENT LIVING					
24.	A. Per Diem [payments			\$ _____	\$ _____	\$ _____
25.	B. Other (non-scheduled)	XXX	XXX	_____	_____	\$ _____
26.	TOTAL INDEPENDENT LIVING (Line 24 of col. 3 & 4 & sum of lines 24 & 25 for col. 5, 6 & 7)	_____	_____	_____	_____	_____
27.	TOTAL ADJUSTED EXPENDITURES SUBJECT REIMBURSEMENT AT 50% (Sum of lines 8, 21, 22 AND 26)	_____	_____	_____	_____	_____
28.	V. RECEIPTS APPLICABLE TO CCF REIMBURSABLE EXPENDITURES				RECEIPTS	
29.	A. Net Probate Court Ordered Collections (75% of Gross Collections) ^{2/}				\$ _____	XXXXXXXXXXXXXXXXXX
30.	B. Government Benefit Collections				_____	XXXXXXXXXXXXXXXXXX
31.	C. Other Receipts				_____	XXXXXXXXXXXXXXXXXX
32.	Total Receipts Applicable to CCF Reimbursement (Sum of lines 29, 30, 31)					\$ _____
33.	NET EXPENDITURES SUBJECT TO (50%) REIMBURSEMENT (Line 27 less line 32)					_____
34.	FOSTER CARE DURING RELEASE APPEAL PERIOD (100% Reimbursable) Attach Court Order(s)					_____
35.	TOTAL STATE REIMBURSEMENT DUE (50% of line 33 plus 100% of line 34)					_____
36.	NET AUDIT ADJUSTMENT (INDICATE PLUS OR MINUS) Within current Fiscal Year Specify Month(s) _____					_____
37.	TOTAL STATE REIMBURSEMENT (Sum of line 35, plus or ,minus line 36)					_____

38. Enter in the space provided the number of days care in out-of-state placements:

Family Foster Care (Lines 3 and 6, col. 3) _____ ; Institutional (Line 19, col. 3) _____ .

^{1/} Includes debit and credit correction transfers (Journal entry corrections of over or under reported expenditures or revenue).

^{2/} 25% may be deferred to offset costs of court ordered collection and deposited in the General Fund.

SECTION B: Expenditures made under the Basic Grant program as authorized by Section 117e of Act 87, PA 1978.

Participating County(s) – If report is for Joint Basic Grant list all Participating Counties.

Line (1)	Service Component (Specify/Identify Component) (2)	Total Grant Amount (3)	Current Month Expenditures (4)	Expenditures Fiscal Year To Date (5)	Balance (Col. 3 – Col. 5) (6)
43.		\$	\$	\$	\$
44.					
45.					
46.					
47.					
48.					
49.					
50.	GRAND TOTAL				

SECTION C:

<p>CERTIFICATION: I certify that (to the best of my knowledge and belief) the data contained in these reports are correct and in accord with the instructions and definitions established by the Department of Human Services for this report; that this is a correct statement of expenditures and that the net reimbursable expenditures represent no cost for capital outlay. Appropriate documentation is available and will be maintained to support costs reported.</p>	<p>Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.</p>
<p>Family Court Judge (Signature) _____ Date _____</p>	<p>AUTHORITY: P.A. 280 of 193 and Section 117 E of Act 87 of P.A. 1978. COMPLETION: Voluntary</p>